Triggers Be Gone!

Asthma Initiative
New Haven Health Department
Toni N. Harp, Mayor

FOR OFFICE USE ONLY
CLIENT #:_____
DATE: _____

Free Medical Equipment and Environmental Triggers Reduction Supplies

Your patient may be eligible to receive the following free asthma self-management and environmental control supplies if he/she **(1) has a diagnosis of asthma (2) has a low income (3) either lacks insurance or lacks coverage for essential asthma control supplies and (3) resides in the City of New Haven**.

Asthma Management Supplies

- ❑ Optichamber spacer
- ❑ Spacer Mask: Child _S _M
- ❑ Nebulizer compressor (Schools only)
- ❑ Nebulizer tubing
- ❑ Nebulizer Mask (Children)
- ❑ Full Range peak flow meter(60-880 L/min)
- ❑ Low Range peak flow meter(30-390L/min)

Environment Control Supplies

- ❑ Cleaning Supplies: wet/dry mop, Antibacterial spray, Mildew spray, Laundry additive, Dust cloth
- ❑ Dust mite powder, Dust mite spray
- ❑ Bed Encasings: _Crib _T _T (long) _F _Q _K
- ❑ Pillow Encasings: _Standard _Queen _King
- ❑ Air Purifiers
- ❑ Roach traps

Does the patient: __lack insurance? **OR** ___ lack coverage for these items? Insurance _____

Does the patient receive any of the following entitlements?

___ Medicaid ___ Medicare ___HUSKY___ Food Stamps ___ WIC V. ___ TANF___ Section 8 Housing ___RAP

Asthma Severity Rating __ Intermittent __ Mild Persistent __ Moderate Persistent __ Severe Persistent

Does patient have an asthma action plan?	**Y**	**N**
Does the daycare/school provider have a copy?	**Y**	**N**
Does the daycare/school provider have medications on hand?	**Y**	**N**

Patient Last Name (Print): _____ **First Name (Print):** _____

DOB: _____/_____/_____ **Sex:**__M__F ___Unknown

Race/Ethnicity: ___Black ___White ____ Asian___Hispanic ____ Unknown ____Other _____

Parent/Guardian Name (Print): _____ **Phone:** _____

Household is female-headed: ___**Yes** ___**No**

Address: _____

Primary Care Provider: _____ **Phone:** _____

Address: _____

PCP Signature: _____ **Date:** _____

Referring Source (Non PCP): ____School Nurse ____ VNA ____Head Start ____ Other _____

Referring Person's Name: _____ **Contact Phone No.** _____

Please mail or fax Attention to: Asthma Project Director, NHHD, 54 Meadow Street, 9th Floor, New Haven, CT 06519
(203) 946-8191 (office) (**203) 946-6509 (fax),** E-mail: **tpatel@newhavenct.gov**
Thank You!!

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